

		FOR BHF USE					

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0047167</u></p> <p>Facility Name: <u>Apostolic Christian Restmor</u></p> <p>Address: <u>1500 Parkside Avenue</u> <u>Morton</u> <u>61550</u> Number City Zip Code</p> <p>County: <u>Tazewell</u></p> <p>Telephone Number: <u>309-284-1400</u> Fax # <u>309-266-7877</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>04/01/1978</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501-c(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Michael Kaiser</u> Telephone Number: <u>309-284-1402</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501-c(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2015</u> to <u>12/31/2015</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="2">Paid Preparer</td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td></td> <td>(Signed) _____</td> </tr> <tr> <td></td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) () Fax # ()</td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____		(Signed) _____		(Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) () Fax # ()
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																							
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																							
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																																							
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Officer or Administrator of Provider	(Signed) _____																																								
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Paid Preparer	(Type or Print Name) _____																																								
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	(Date) _____																																								
	(Print Name and Title) _____																																								
	(Firm Name & Address) _____																																								
	(Telephone) () Fax # ()																																								

Facility Name & ID Number Apostolic Christian Restmor

0047167 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	116	Skilled (SNF)	116	42,340	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	12	ICF/DD 16 or Less	12	4,380	6
7	128	TOTALS	128	46,720	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	3,438	26,245	3,028	32,711	8
9	SNF/PED					9
10	ICF		5,308		5,308	10
11	ICF/DD					11
12	SC		3,132		3,132	12
13	DD 16 OR LESS					13
14	TOTALS	3,438	34,685	3,028	41,151	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.08%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

meals on wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 4/1/2008

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 42 and days of care provided 3,028

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number

Apostolic Christian Restmor

0047167

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	660,415	45,350		705,765		705,765	705,765			1
2	Food Purchase		384,716		384,716	(17,351)	367,365	(24,441)	342,924		2
3	Housekeeping	153,927	63,605		217,532		217,532	217,532			3
4	Laundry	107,103	16,043		123,146		123,146	(3,135)	120,011		4
5	Heat and Other Utilities			195,113	195,113		195,113	195,113			5
6	Maintenance	204,079	67,700	272,395	544,174	(8,076)	536,098	536,098			6
7	Other (specify):*			19,996	19,996		19,996	19,996			7
8	TOTAL General Services	1,125,524	577,414	487,504	2,190,442	(25,427)	2,165,015	(27,576)	2,137,439		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	12,000			9
10	Nursing and Medical Records	4,163,980	304,527	2,798	4,471,305		4,471,305	4,471,305			10
10a	Therapy			411,187	411,187		411,187	411,187			10a
11	Activities	200,071			200,071		200,071	(116)	199,955		11
12	Social Services	214,251			214,251		214,251	214,251			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,578,302	304,527	425,985	5,308,814		5,308,814	(116)	5,308,698		16
	C. General Administration										
17	Administrative	255,153			255,153		255,153	(37,500)	217,653		17
18	Directors Fees										18
19	Professional Services			51,273	51,273		51,273	(12,730)	38,543		19
20	Dues, Fees, Subscriptions & Promotions			53,190	53,190		53,190	(23,449)	29,741		20
21	Clerical & General Office Expenses	274,317	24,051	133,641	432,009	(41,943)	390,066	(2,766)	387,300		21
22	Employee Benefits & Payroll Taxes			1,521,927	1,521,927	17,351	1,539,278	(15,588)	1,523,690		22
23	Inservice Training & Education										23
24	Travel and Seminar			47,185	47,185	(3,327)	43,858	(6,061)	37,797		24
25	Other Admin. Staff Transportation			2,872	2,872	3,327	6,199	(3,699)	2,500		25
26	Insurance-Prop.Liab.Malpractice			104,018	104,018		104,018	104,018			26
27	Other (specify):*										27
28	TOTAL General Administration	529,470	24,051	1,914,106	2,467,627	(24,592)	2,443,035	(101,793)	2,341,242		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,233,296	905,992	2,827,595	9,966,883	(50,019)	9,916,864	(129,485)	9,787,379		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Apostolic Christian Restmor

#0047167

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			580,016	580,016		580,016		580,016			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					50,019	50,019		50,019			35
36	Other (specify):*											36
37	TOTAL Ownership			580,016	580,016	50,019	630,035		630,035			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			190,499	190,499		190,499		190,499			39
40	Barber and Beauty Shops	34,211	4,506		38,717		38,717		38,717			40
41	Coffee and Gift Shops			12,779	12,779		12,779	(12,779)				41
42	Provider Participation Fee			277,547	277,547		277,547		277,547			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	34,211	4,506	480,825	519,542		519,542	(12,779)	506,763			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,267,507	910,498	3,888,436	11,066,441		11,066,441	(142,264)	10,924,177			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Apostolic Christian Restmor

0047167

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

BHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Apostolic Christian Restmor

ID# 0047167

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non Allowable Seminar	\$ (1,476)	24	1
2	Non Allowable Dues & Subs	(9,682)	20	2
3	Promotion	(12,979)	20	3
4	Employee Meal Income	(14,353)	22	4
5	Guest Meal Income	(4,748)	2	5
6	Misc Expense	(830)	21	6
7	Misc Income	(737)	21	7
8	Auto Expense	(3,699)	25	8
9	Non Allowable Professional Fees	(12,730)	19	9
10	Meals On Wheels Expense	(19,693)	2	10
11	Sunshine Cart Expense	(116)	11	11
12	POM Management Fee	(37,500)	17	12
13	Travel Out of State	(4,585)	24	13
14	Penalties	(788)	20	14
15	Interest Income Pension	(1,235)	22	15
16	Private Pay Laundry	(3,135)	4	16
17	Finance Charges	(1,199)	21	17
18	Nonoperating Expense	(12,779)	41	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(142,264)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Apostolic Christian Restmor# 0047167

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(24,441)	0	0	0	0	0	0	0	0	0	0	(24,441)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(3,135)	0	0	0	0	0	0	0	0	0	0	(3,135)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(27,576)	0	0	0	0	0	0	0	0	0	0	(27,576)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(116)	0	0	0	0	0	0	0	0	0	0	(116)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(116)	0	0	0	0	0	0	0	0	0	0	(116)	16
	C. General Administration													
17	Administrative	(37,500)	0	0	0	0	0	0	0	0	0	0	(37,500)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(12,730)	0	0	0	0	0	0	0	0	0	0	(12,730)	19
20	Fees, Subscriptions & Promotions	(23,449)	0	0	0	0	0	0	0	0	0	0	(23,449)	20
21	Clerical & General Office Expenses	(2,766)	0	0	0	0	0	0	0	0	0	0	(2,766)	21
22	Employee Benefits & Payroll Taxes	(15,588)	0	0	0	0	0	0	0	0	0	0	(15,588)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(6,061)	0	0	0	0	0	0	0	0	0	0	(6,061)	24
25	Other Admin. Staff Transportation	(3,699)	0	0	0	0	0	0	0	0	0	0	(3,699)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(101,793)	0	0	0	0	0	0	0	0	0	0	(101,793)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(129,485)	0	0	0	0	0	0	0	0	0	0	(129,485)	29

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Restmor# 0047167

Report Period Beginning:

01/01/2015 Ending:

Summary B

12/31/2015

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(12,779)	0	0	0	0	0	0	0	0	0	0	(12,779)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(12,779)	0	0	0	0	0	0	0	0	0	0	(12,779)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(142,264)	0	0	0	0	0	0	0	0	0	0	(142,264)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marty Rollins						
Bruce Sauder						
Nate Koch						
Brian Bahr						
Gary Psinas						
Joe Zimmerman						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1									\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Apostolic Christian Restmor

0047167 Report Period Beginning: 01/01/2015

Ending: 2/31/2015

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Apostolic Christian Restmor

0047167

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	A. Directly Facility Related															
	Long-Term															
1							\$	\$			\$					
2																
3																
4																
5																
	Working Capital															
6																
7																
8																
9	TOTAL Facility Related						\$	\$			\$					
	B. Non-Facility Related*															
10																
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$	\$			\$					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2014 report.	\$			1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$			2
3.	Under or (over) accrual (line 2 minus line 1).	\$			3
4.	Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	\$			4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$			5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$			6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$			7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2010	_____	8	
		2011	_____	9	
		2012	_____	10	
		2013	_____	11	
		2014	_____	12	
FOR BHF USE ONLY					
		13	FROM R. E. TAX STATEMENT FOR 2014 \$		13
		14	PLUS APPEAL COST FROM LINE 5 \$		14
		15	LESS REFUND FROM LINE 6 \$		15
		16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Apostolic Christian Restmor COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0047167

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>_____</u>	\$ <u>_____</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 86,000 B. General Construction Type: Exterior Brick Frame Stick Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>facility site</u>	<u>849,420</u>		<u>\$ 327,810</u>	1
2	<u>vacant land</u>	<u>435,600</u>		<u>75,000</u>	2
3	TOTALS	1,285,020		\$ 402,810	3

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	128			2008	\$ 15,081,596	\$ 377,040	40	\$ 377,040	\$	\$ 2,922,060	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Land Site preparation and grading		2008	395,786						9
10		Remote unattached storage building		2008	207,121	5,178	40	5,178		40,130	10
11		Road and parking area		2008	194,661	9,733	20	9,733		75,431	11
12		Brick Edging and Landscaping		2008	10,923	546	20	546		4,144	12
13		New Sidewalk		2009	8,245	550	15	550		3,483	13
14		Concrete drainage ways for stormwater		2009	10,656	533	20	533		3,286	14
15		Additional Heat Pump for Spa area		2009	7,020	468	15	468		3,120	15
16		Additional Lighting		2009	9,232	615	15	615		4,100	16
17		New Ventilators in Spa area		2009	6,791	453	15	453		2,990	17
18		Additional Smoke Devices		2009	2,667	178	15	178		1,216	18
19		Additional Door Holders		2009	2,758	184	15	184		1,165	19
20		Courtyard concrete finish		2010	11,808	590	20	590		3,393	20
21		Re keying all doors		2010	9,980	270	37	270		1,530	21
22		Smokedoors		2010	10,570	286	37	286		1,597	22
23		New Trees		2010	5,000	135	37	135		709	23
24		New Trees		2011	3,900	108	36	108		468	24
25		Linoleum in laundry room		2011	7,667	639	12	639		3,088	25
26		Paneling in patient rooms		2011	9,550	796	12	796		3,648	26
27		Geo Thermal Retrocommissioning		2012	357,300	10,209	35	10,209		39,134	27
28		Enclose Porches in resident living rooms		2012	25,892	740	35	740		2,343	28
29		Lighting Upgrade on exterior doors		2012	3,402	97	35	97		299	29
30		Air Filters		2013	3,000	86	35	86		251	30
31		Air Conditioning Reconfiguration		2013	48,300	1,380	35	1,380		3,450	31
32		Automatic Doors for four outside entrances		2013	23,651	676	35	676		1,749	32
33		Kick Resistant Panel		2013	5,630	161	35	161		402	33
34		Heat Pump		2014	5,418	159	34	159		292	34
35		LED Outside Lighting		2014	10,113	297	34	297		520	35
36		Paneling in patient rooms		2014	10,000	294	34	294		490	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Apostolic Christian Restmor

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	A/C Reconfiguration	2014	\$ 8,120	\$ 239	34	\$ 239	\$	\$ 299	37
38	Revise electrical outlets	2014	18,900	556	34	556		602	38
39	Hearing Loop	2015	6,985	200	32	200		200	39
40	ID Card System	2015	6,665	174	32	174		174	40
41	Paneling	2015	7,118	130	32	130		130	41
42	Water Softener	2015	20,000	260	32	260		260	42
43	Bathroom Flooring	2015	8,801	92	32	92		92	43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 16,565,226	\$ 414,052		\$ 414,052	\$	\$ 3,126,245	70

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,134,210	\$ 155,868	\$ 155,868	\$	4--15	\$ 1,264,386	71
72	Current Year Purchases	14,522	2,004	2,004		4--8	2,004	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,148,732	\$ 157,872	\$ 157,872	\$		\$ 1,266,390	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1996 Dodge Van	1996	\$ 21,621	\$	\$	\$		\$ 21,621	76
77	Machinery			8,720					8,720	77
78	Patient Transportation	Chevy Ex Pas Van	2010	24,149	3,450	3,450		7	18,112	78
79	Patient Transportation	2009 Dodge Braun	2011	32,500	4,643	4,643			20,893	79
80	TOTALS			\$ 86,990	\$ 8,093	\$ 8,093	\$		\$ 69,346	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 19,203,758	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 580,017	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 580,017	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,461,981	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Apostolic Christian Restmor

0047167

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 50,019 Description: Several copiers and patient care bus

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Apostolic Christian Restmor # 0047167 Report Period Beginning: 01/01/2015 Ending: 12/31/2015
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)		Total Units (Column 2 + 4)		Total Cost (Col. 3 + 5 + 6)					
			Units of Service	Cost	Units	Cost										
1	Licensed Occupational Therapist		hrs	\$			\$	35,745	\$				\$	35,745	1	
2	Licensed Speech and Language Development Therapist		hrs					62,612						62,612	2	
3	Licensed Recreational Therapist		hrs												3	
4	Licensed Physical Therapist		hrs					58,957						58,957	4	
5	Physician Care		visits					3,040						3,040	5	
6	Dental Care		visits												6	
7	Work Related Program		hrs												7	
8	Habilitation		hrs												8	
9	Pharmacy		# of prescripts							157,138				157,138	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs												10	
11	Academic Education		hrs												11	
12	Other (specify): <u>Lab</u>							30,321						30,321	12	
13	Other (specify):														13	
14	TOTAL			\$			\$	190,675	\$	157,138		\$	347,813	14		

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Apostolic Christian Restmor# 0047167Report Period Beginning: 01/01/2015

Ending:

12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,094,180	\$	1
2	Cash-Patient Deposits	8,604		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>52,830</u>)	572,846		3
4	Supply Inventory (priced at)	92,179		4
5	Short-Term Investments	2,843,947		5
6	Prepaid Insurance	69,164		6
7	Other Prepaid Expenses	42,120		7
8	Accounts Receivable (owners or related parties)	51,624		8
9	Other(specify): <u>Blueprints</u>	96,730		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,871,394	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	402,810		13
14	Buildings, at Historical Cost	15,081,596		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,235,721		16
17	Accumulated Depreciation (book methods)	(4,461,977)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,116,623		21
22	Other Long-Term Assets (specify):	856,711		22
23	Other(specify): <u>building imp</u>	652,570		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 16,884,054	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 21,755,448	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 273,812	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,604		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	658,471		30
31	Accrued Taxes Payable (excluding real estate taxes)	34,089		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued pension</u>	407,864		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,382,840	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,382,840	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 20,372,608	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 21,755,448	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 19,913,223	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 19,913,223	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	459,385	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 459,385	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 20,372,608	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 10,494,514	1	
2	Discounts and Allowances for all Levels	(955,615)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,538,899	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	808,701	6	
7	Oxygen	74,816	7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 883,517	8	
C. Other Operating Revenue				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop		12	
13	Barber and Beauty Care	43,913	13	
14	Non-Patient Meals	41,166	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	126,531	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory	26,095	19	
20	Radiology and X-Ray		20	
21	Other Medical Services	270,868	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 508,573	23	
D. Non-Operating Revenue				
24	Contributions	532,916	24	
25	Interest and Other Investment Income***	16,342	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 549,258	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28			28	
28a		45,579	28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 45,579	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,525,826	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	2,190,442	31	
32	Health Care	5,308,814	32	
33	General Administration	2,467,627	33	
B. Capital Expense				
34	Ownership	580,016	34	
C. Ancillary Expense				
35	Special Cost Centers	241,995	35	
36	Provider Participation Fee	277,547	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,066,441	40	
41	Income before Income Taxes (line 30 minus line 40)**	459,385	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 459,385	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Apostolic Christian Restmor

0047167

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,820	2,080	\$ 97,342	\$ 46.80	1
2	Assistant Director of Nursing	2,136	2,337	82,045	35.11	2
3	Registered Nurses	39,390	43,099	1,181,679	27.42	3
4	Licensed Practical Nurses	20,630	22,690	541,800	23.88	4
5	CNAs & Orderlies	124,367	135,011	1,950,735	14.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,005	3,339	63,669	19.07	8
9	Activity Director	1,894	1,986	30,998	15.61	9
10	Activity Assistants	12,696	13,862	169,073	12.20	10
11	Social Service Workers	5,468	5,732	127,310	22.21	11
12	Dietician	819	879	19,833	22.56	12
13	Food Service Supervisor	1,920	2,160	70,844	32.80	13
14	Head Cook	6,660	7,284	115,232	15.82	14
15	Cook Helpers/Assistants	40,776	43,763	454,506	10.39	15
16	Dishwashers					16
17	Maintenance Workers	8,700	9,577	204,079	21.31	17
18	Housekeepers	13,011	14,016	153,927	10.98	18
19	Laundry	7,989	8,775	107,103	12.21	19
20	Administrator	1,694	2,080	136,040	65.40	20
21	Assistant Administrator	1,955	2,240	119,113	53.18	21
22	Other Administrative	3,348	3,785	86,941	22.97	22
23	Office Manager					23
24	Clerical	9,960	11,087	261,089	23.55	24
25	Vocational Instruction					25
26	Academic Instruction	1,805	2,034	57,970	28.50	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	7,970	8,778	136,428	15.54	31
32	Other Health C: <u>Dir Mem Supp</u>	1,785	2,062	52,312	25.37	32
33	Other(specify) <u>Vol Hair Care</u>	2,918	3,505	47,439	13.53	33
34	TOTAL (lines 1 - 33)	322,716	352,161	\$ 6,267,507 *	\$ 17.80	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director	12,000	9--3	36	
37	Medical Records Consultant	34	2,461	10--3	37
38	Nurse Consultant			38	
39	Pharmacist Consultant			39	
40	Physical Therapy Consultant			40	
41	Occupational Therapy Consultant			41	
42	Respiratory Therapy Consultant			42	
43	Speech Therapy Consultant			43	
44	Activity Consultant			44	
45	Social Service Consultant			45	
46	Other(specify)			46	
47				47	
48				48	
49	TOTAL (lines 35 - 48)	34	\$ 14,461	49	

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
John Kelley	Administrator		\$ 136,040	Workers' Compensation Insurance	\$ 172,746	IDPH License Fee	\$		
Michael Kaiser	Asst Admin		119,113	Unemployment Compensation Insurance	11,176	Advertising: Employee Recruitment		8,836	
				FICA Taxes	452,949	Health Care Worker Background Check (Indicate # of checks performed _____)			
				Employee Health Insurance	440,753	Patient Background Checks			
				Employee Meals	2,998	Tazewill County Health Dept		350	
				Illinois Municipal Retirement Fund (IMRF)*		ACA transitional ins fee		5,280	
				Disability Ins	1,400	Leading Age		11,375	
				Employee Relations	8,957	Other		3,900	
				403-b Cost	400,276				
				Uniform Rental	18,745	Less: Public Relations Expense	(
				Employee Hiring and Training	1,424	Non-allowable advertising	(
				Tuition Reimbursement	12,266	Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 255,153	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,523,690	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 29,741
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description				Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel	13,199	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	Seminar Expense	13,657	
							Relias Training	10,941	
							Entertainment Expense	(
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 51,273	TOTAL		\$	TOTAL	\$ 37,797	

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Apostolic Christian Restmor# 0047167Report Period Beginning: 01/01/2015Ending: 12/31/2015**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Leading Age 11375
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 4-12
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 59,161 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 277,547
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 17,351 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 14,353
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? Majority
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Review
Firm Name: Clifton larson
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. No
Attach invoices and a summary of services for all architect and appraisal fees.

SCHEDULE XVII PAGE 19
LINE 28a

Social Activities Income	2293
Private Pay Laundry	3135
Finance Charges	1199
Personal Supplies Income	599
Sunshine Cart Income	116
Misc Income	75
POM Management Fee	37500
Misc Income	662
	45579